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	175277	A. BUILDING _____ B. WING _____	01/15/2015

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BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #s 79179,80008,and 82817. A revised copy of the 2567 was sent to the facility on 1/20/15.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility reported a census of 100 residents. The sample included 21 residents. Based on observation and interview the facility failed to provide labeled care items for 2 of 3 living units, and failed to provide a comfortable and clean environment for residents on 2 of 3 resident living units. Findings included: - On initial tour on 1/7/15 from 9:30 A.M. to 4:30 P.M. and on 1/8/15 at 7:00 A.M. to 11:00 A.M. revealed on the special care unit unlabeled denture cup, hair brushes, and combs. On the north unit unlabeled hair brushes and hair pick. On 1/12/15 at 3:45 P.M. direct care staff W stated the social worker used a label gun to label care items and staff used a black marker to label resident care items when needed. On 1/12/15 at 4:15 P.M. licensed nursing staff K stated all staff were responsible for labeling	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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resident care items.

On 1/13/15 at 7:30 A.M. direct care staff LL stated staff labeled resident care items and the care items should be stored in the resident's bathroom cabinet.

On 1/13/15 at 12:16 P.M. administrative nursing staff F stated certified nursing staff labeled resident care items and resident care items should be labeled.

On 1/13/15 at 3:35 P.M. administrative nursing staff D stated staff should ensure resident care equipment were labeled.

The facility failed to label resident care items.

- An environmental tour on 1/13/15 at 10:00 A.M. to 11:00 A.M. with maintenance staff X revealed:

On the special care unit there were gouged walls in resident bathrooms and resident room walls, holes in a wall, black marks along resident rooms and bathroom walls, a broken door stop, and a lose call light panel plate.

On the south unit there were chipped paint in a resident bathroom, a short bathroom pull cord, rust on the front part of a toilet, and a sink drainage plug laid on the sink.

On 1/13/15 at 11:05 A.M. maintenance staff X acknowledged the environmental concerns. She/he stated the interior and exterior buildings were checked monthly for repairs and by report submitted by staff and housekeeping.

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F 253	Continued From page 2 The facility failed to maintain a clean and comfortable environment for the residents.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: - Review of the resident #41's January 2015 Physician Order Sheet (POS) identified the resident was admitted to the facility on 12/8/14 with diagnoses of right femoral and pubic rami fractures (broken pelvic and thigh bone). The resident's admission Minimum Data Set (MDS) dated 12/15/14 identified the resident scored 14 (cognition intact) on the Brief Interview	F 279		

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for Mental Status, had no behaviors, required extensive staff assistance with bed mobility, transfers, dressing, toilet use, bathing and locomotion on/off the unit. The MDS identified the activity of walking in the room/corridor did not occur, required staff supervision with eating and limited staff assistance with personal hygiene. The MDS identified the resident was occasionally incontinent of urine, always continent of bowel and was not on a toileting program. The MDS recorded the resident weighed 96 pounds, was at risk for the development of pressure ulcers, did not have any unhealed pressure ulcers, had a pressure reducing device on his/her bed and in his/her chair and was not on a turning/repositioning program.

The resident's Activity of Daily Living Care Area Assessment (CAA) dated 12/17/14 included the resident required staff assistance for mobility, transfers, locomotion, toileting and bathing. The resident's pain limited his/her ability to function fully and the resident was non-weight bearing on his/her right leg.

The resident's Nutritional Status CAA dated 12/17/14 included the resident was at risk for an alteration in skin due to a recent fall which resulted in fractures of the pelvic/thigh and pain.

The resident's Pressure Ulcer CAA dated 12/17/14 included the resident was at risk for skin breakdown secondary to requiring extensive staff assistance for mobility (leg/pelvic fracture). The resident risks included incontinence, mobility needs, potential for friction and shearing and the resident was underweight.

The resident's Braden Scale (scale used to

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predict the development pressure ulcers) dated 12/8/14 identified the resident scored 14. According to the legend a score of 13 to 14 represented the resident was at moderate risk for the development of pressure ulcers.

The resident's care plan developed on 12/17/14 and revised on 12/22/14 addressed the resident had a alteration in his/her activity of daily living (ADL) abilities related to a fracture of the femur and pelvic fracture and required staff assistance with ADL's. The resident enjoyed sitting in his/her recliner. The resident received a regular diet, staff encouraged the resident to drink fluids and eat snacks. The Registered Dietician (RD) evaluated the resident annually and as needed, staff administered supplements and weighed the resident as physician ordered. The resident was at risk for skin problems related to incontinence, staff applied cream to the resident's buttock as physician ordered, the resident utilized a foot cradle on his/her bed to keep the covers off of his/her feet, had a low air loss mattress (pressure relieving device), staff monitored the resident's skin during bathing, the licensed nurse performed weekly skin assessments and reported open areas to the resident's physician and staff performed the Braden Scale on a quarterly basis. The care plan addressed the resident was at risk for bowel and bladder incontinence. Staff performed laboratory testing as indicated. An entry dated 12/18/14 included staff placed a pressure relieving device in the resident's recliner and offered the resident Carnation Instant Breakfast. An entry dated 12/22/14 included the resident had (2) Stage 2 pressure ulcers on his/her sacrum (large triangular bone between the two hip bones) . Staff cleaned the pressure ulcers with soap and water and patted dry,

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applied Duoderm (dressing used to promote the healing of wounds) and changed the dressing every 72 hours and as needed until healed.

The resident's care plan did not include a turning/repositioning schedule/program for the resident. The care plan did not include how staff protected skin to skin contact of the resident's bony prominence's.

The resident's Weekly Wound Tracking Form on 1/7/15 revealed the resident had a Pressure ulcer, #1 was a Stage 2 and measured 1.0 cm by 0.5 cm, pressure ulcer #2 remained healed and staff treated the area with Duoderm.

On 1/12/15 at 8:20 A.M. observation revealed the resident's bed had a low air loss mattress.

On 1/12/15 at 2:25 P.M. the resident laid in bed on his/her left side. Observation did not reveal a foot cradle on the resident's bed. Further observations revealed the resident's feet were not offloaded nor were there devices between the resident's knees.

On 1/12/15 at 2:30 P.M. the resident laid in bed on his/her left side. Observation did not reveal a foot cradle on the resident's bed. Further observations revealed the resident's feet were not off-loaded nor were there devices between the resident's knees.

On 1/12/15 at 2:42 P.M. the resident laid in bed on his/her left side. Observation did not reveal a foot cradle on the resident's bed. Further observations revealed the resident's feet were not offloaded nor were there devices between the resident's knees.

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On 1/12/15 at 3:00 P.M. administrative nursing staff F entered the resident's room. Administrative nursing staff F stated the resident complained that his/her bottom was hurting and he/she was going to assess the resident's bottom. Observation revealed the Duoderm in a rolled position on the resident's coccyx and per administrative nursing staff F the resident was starting to have a bowel movement. Administrative nursing staff F removed the Duoderm and cleansed the area. After the Duoderm was removed and the area was cleansed the resident stated the pain was better. Administrative nursing staff F stated the resident had a pinpoint scabbed area on his/her coccyx. Observation confirmed administrative nursing staff F statement. Further observation revealed scar tissue on the side of the pinpoint scabbed area. Nursing administrative staff F stated the resident had also had another pressure ulcer on his/her coccyx which was healed and the scar tissue was where the previously pressure ulcer was.

On 1/13/15 at 2:16 P.M. administrative nursing staff F stated he/she was not sure if the resident was on a turning/repositioning program.

On 1/13/15 at 2:47 P.M. direct care staff VV stated the resident at times required staff assistance. He/she stated the resident was not on a turning/repositioning program.

The facility failed to develop a comprehensive care plan that included turning/repositioning program and protection of the resident's bony prominences for this resident the facility assessed at risk for the development of pressure

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ulcers upon admission and developed a facility acquired pressure ulcer.

- Resident #52's Significant Change Minimum Data Set (MDS) dated 12/17/14 identified the resident scored 8 (moderate impaired cognition) on the Brief Interview for Mental Status, displayed verbal behaviors 1 to 3 days of the 7 day assessment period and did not reject care. The MDS identified the resident required extensive staff assistance with bed mobility, transfers, toilet use and locomotion on/off the unit, limited staff assistance with personal hygiene and the activity of walking in the room/corridor did not occur. The MDS identified the resident was always incontinent of urine, had a condition or chronic disease that may result in life expectancy of less than 6 months, weight of 192 pounds and had not experienced a weight loss. The MDS identified the resident was at risk for the development of pressure ulcers, had (1) Stage 2 pressure ulcer present upon admission/readmission, had a pressure relieving device on his/her bed and in his/her chair and was not on a repositioning/turning program.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/18/14 included the resident scored less than 13 on the Brief Interview for Mental Status and displayed verbal behaviors. The resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The resident's Activity of Daily Living CAA dated 12/18/14 included the resident was weak from a recent hospitalization for pneumonia (-inflammation of the lungs)/respiratory failure (respiratory system failed in one or both of its gas

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exchange functions) and received hospice services. The resident required extensive and at times was totally dependent upon staff for mobility, transfers, bathing, locomotion, dressing, toileting and eating. The resident does not walk and relied on staff or family to propel his/her wheelchair.
The resident's incontinence CAA dated 12/18/14 included the resident stated he/she had a history of incontinence especially at night. The resident had a diagnosis of dementia which may impair his/her to make a decision that he/she needed to toilet or ask for assistance.

The resident's Behavioral Symptom CAA dated 12/18/14 included the resident yelled out, had verbal behaviors when staff assisted him/her with care.

The resident's Nutritional Status CAA dated 12/18/14 included the resident was overweight and had edema. The resident's serum albumin was low at 2.7 grams per deciliter and the resident had a Stage 2 pressure ulcer on his/her coccyx upon readmission.

The resident's Pressure Ulcer CAA dated 12/18/14 included the resident required significant staff assistance to reposition himself/herself, was incontinent of urine and bowel and was overweight. The resident's Braden Scale score was 14, the resident had a low albumin, indicators the resident was at high risk for skin breakdown. The resident was a diabetic, had a history of leg wounds and had diagnoses of Peripheral Artery Disease (abnormal condition affecting the blood vessels) and severe arthritis (-inflammation of a joint characterized by pain, swelling, heat, redness and limitation of

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movement). The resident's dementia limited his/her ability to make safe decisions. The resident had behaviors of refusing cares and yelling at staff. The resident was admitted from a hospital with a wound on his/her coccyx area and received hospice services for Chronic Obstruction Pulmonary Disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The resident's care plan dated 12/23/14 included the resident had a diagnosis of dementia and the resident's behavior made him/her resistive to care. The resident was admitted to hospice service on 12/11/14 for COPD. The resident required staff assistance with bed mobility, transfers, getting in/out of the bed and with toileting due to weakness and arthritis. The resident utilized transfer bars to help him/her with bed mobility and transfers. The resident received a regular diet and was overweight, and staff offered the resident fruit at each meal. The Registered Dietician (RD) visited the resident annually and as needed and staff weighed the resident as indicated. The resident was at risk for skin problems due to incontinence, requiring staff assistance with mobility. The resident had a pressure ulcer on his/her bottom, utilized a heel up device in bed which elevated the resident's legs and decreased edema. The resident utilized a low air loss mattress, staff monitored the healing of the resident's pressure ulcer, staff monitored the resident's skin during bathing and the licensed nurse performed weekly skin assessments, quarterly Braden scale (scale used to predict the development of pressure ulcers) assessments and treated the pressure ulcer as physician ordered.

The resident's care plan did not include a

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turning/repositioning program nor did it include the resident refused the Pro-Stat (liquid protein supplement). The resident's care plan did not include the education staff provided to the resident/family regarding the consequences of refusal of care and treatment to promote the healing of the pressure ulcer.

Review of the resident's weekly wound log revealed on 01/7/15: Stage 2 coccyx pressure ulcer that measured 1.0 cm by 1.0 cm and the current treatment was Duoderm.

On 1/12/15 at 9:00 A.M. the resident laid in bed on his/her back. Observation revealed the resident's had a low air loss mattress on his/her wheelchair and a pressure relieving device in his/her wheelchair. Observation revealed no heel up device in place, the resident's feet were not off-loaded and nothing between the resident's legs to prevent skin to skin contact.

On 1/12/15 at 9:40 A.M. direct care staff SS and TT were in the resident's room. The resident asked staff to lower his/her pants so the surveyor could observe his/her buttock. Observation revealed the resident had on an incontinent brief, staff removed the brief and observation revealed the resident had a pressure ulcer in the crease of his/her buttock that measured approximately 1.0 cm by 0.5 cm and the middle of the wound bed with yellow slough. Further observation revealed no dressing covering the pressure ulcer. At 9:48 A.M. direct care staff SS and TT transferred the resident from the bed to his/her wheelchair via the mechanical lift.

The facility failed to develop a comprehensive care plan that included an individualized

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turning/repositioning program, and interventions to ensure the resident's bony prominence's were protected to prevent the development of new pressure ulcers for this resident admitted with a pressure ulcer.

The facility identified a census of 100 residents. The sample size included 21 residents. Based on observation, interview, and record review the facility failed to provide an individualized care plan for 3 (#52,#41, and #66) of the 21 residents sampled.

Findings included:

- Diagnoses listed on the Physicians Order Sheet (POS) dated 1/1/15 for resident #66 of hypothyroidism,(abnormally low activity of the thyroid gland), and advanced dementia,(a loss of mental ability severe enough to interfere with normal activities of daily living).

The Quarterly Minimum Data Set (MDS) dated10/9/14 listed long and short term memory problems. He/she was totally dependent on 2 staff members for all activities of daily living. He/she required the assistance of 1 staff member for eating. He/she used a wheelchair for mobility; with staff assistance. The assessment identified the resident had functional limitation impairments on both upper and lower extremities and did not receive active or passive range of motion.

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The Annual Minimum Data Set (MDS) dated12/18/14 listed long and short term memory problems. He/she was totally dependent on 2 staff members for all activities of daily living. He/she required the assistance of 1 staff member for eating. He/she used a wheelchair for mobility, with staff assistance. The assessment identified the resident had functional limitation impairments on both upper and lower extremities and did not receive active or passive range of motion.

The Care Area Assessment (CAA) for Special treatments procedures, and programs did not trigger.

The care plan dated 12/30/14 did not identify the resident had palm protectors placed bilaterally, the duration of placement, or staff responsible to assure the resident received this service.

On 1/12/14 at 8:15 A.M. resident #66 laid in bed, white palm grips in place on both hands.

On 1/12/14 at 11:00 A.M. the resident sat in the common area during current events with palm protectors in place bilaterally.

On 1/12/14 at 4:15P.M. direct care staff S and RR transferred the resident from the bed to the chair using the sling lift. Direct care staff RR stated the resident was totally dependent on staff for all cares,the palm protectors were put on in the A.M. and taken off at bedtime, washed and hung to dry for the next day.

On 1/13/15 at9:00 A.M. direct care staff QQ stated the resident was total care, the palm protectors were applied when he/she gets up in

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F 279	Continued From page 13 the morning and were removed at night. On 1/13/15 at 2:30 P.M. licensed staff J stated the resident had palm protectors and should be addressed in the care plan. Review of the policy for care plan development and communication dated/ revised on 9/25/14 was to ensure the effective delivery of comprehensive, coordinated, quality of care in an organized manner designated to meet the ongoing needs of Five Star Residents. The facility failed to develop a comprehensive care plan for assistive devices used for this cognitively impaired totally dependent resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 100. The sample included 21 residents. Based on observation, record review, and interview, the facility failed to update a fall care plan for 1 (#94) and failed to update a care plan for bathing preferences for 1 (#96) sampled resident.

Findings included:

- The quarterly Minimum Data Set (MDS) dated 10/22/14 for resident #94 revealed a Brief Interview for Mental Status (BIMS) score of 8 (moderately impaired cognition). The resident was independent with bed mobility, transfers and eating. She/he required limited assistance of one person with dressing, locomotion on/off the unit, and required supervision of one person for toilet use and personal hygiene. The resident was not steady and was able to stabilize her/himself without assistance with moving from a seated to standing position, moving on/off the toilet, and surface-to-surface transfer. There was impairment on one side of her/his lower extremity and the resident used a wheelchair (w/c) for mobility. The resident had one non-injury fall since admission and/or prior assessment.

The Activity for Daily Living (ADL) Care Area Assessment (CAA) dated 8/12/14 revealed the resident required assistance with toileting, hygiene, and bathing support. The resident was cognitively impaired and had a diagnosis of hip necrosis (death of cells, tissues, or organs) which limited her/his mobility and transfers, increased

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her/his fall risk and balance. The resident did not put weight on her/his right leg and kept it elevated with a foot pedal.

The Fall CAA dated 8/12/14 revealed the resident was unsteady with transfers. She/he had diagnoses of degenerative joint disease (Osteoarthritis) and necrosis of the hip. The resident was partial weight bearing, had kept her/his right leg extended, and self-transferred to the bed and bathroom without asking for assistance. The resident was alert and oriented and had no recent falls.

The fall care plan dated 10/29/14 revealed staff would anticipate the resident's needs with bathroom issues, eating, and grooming, placed dycem (a non-slip sheet of plastic) in the resident's wheelchair, and kept the resident's right leg elevated on a foot pedal. The resident used a w/c for mobility and was reminded to call for assistance with transfers and ambulation. On 9/2/14, the resident had a non-injury fall and staff placed yellow tape on the resident's call pendant to remind the resident to call for assistance.

The fall care plan lacked documentation staff placed non-slip strips by both sides of her/his bed as a fall intervention of 12/25/14.

The nursing notes dated 12/25/14 at 9:15 P.M. revealed at 8:00 P.M. a certified nursing staff notified staff the resident was on the floor. The resident sat upright on the floor next to her/his bed with both lower extremities extended in front of her/him. The resident was alert, disoriented to time, and was not wearing her/his oxygen. An unlocked wheelchair was positioned behind the resident. Resident stated she/he tried to get into

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bed and when she/he grabbed a hold of a chair for support the chair slid and she/he lost her balance falling onto her/his buttocks. The resident denied any pain and hitting her/his head. No visible injuries were noted. The resident wore shoes and range of motion was within normal limits (WNL). Vital signs were obtained and neuro checks initiated and WNL. The resident was encouraged to call for assistance, to keep oxygen on, and not self-transfer. The nurse manager and director of nursing (DON) were notified. Intervention put into place were nonskid strips on the floor on both sides of the resident's bed. Staff faxed the physician regarding the fall and message left for Durable Power of Attorney (DPOA).

Observation on 1/8/15 at 2:44 P.M. revealed the resident layed in a low bed; call light within reach, and non-skid strips by both sides of the bed.

On 1/12/15 at 3:45 P.M., direct care staff W stated fall interventions were fall mats on both side of the bed, non-skid shoes or socks, call light within reach, and non-slip strips by the bed.

On 1/12/15 at 4:15 P.M. licensed nursing staff K stated fall interventions were non-slip strips in the resident's bathroom, and call light within reach. All nursing staff were notified of resident changes, new orders, and updated care plans. Staff reviewed care plans with care plan meetings.

On 1/13/15 at 7:30 A.M., direct care staff LL stated fall interventions were nonskid shoes/socks, fall mats by both sides of the bed, call light within reach, and was not aware of use of non-slip strips by the resident's bed.

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On 1/13/15 at 12:16 P.M. administrative nursing staff F stated fall interventions were yellow tape to the resident's call pendant to remind her/him to use her/his call light for assistance and non-slip strips by both side of the resident's bed. Staff should have updated the care plan to reflect the use on non-strip slips by the resident's bed as a fall intervention.

On 1/13/15 at 3:35 P.M. administrative nursing staff D stated staff should have updated the resident's care plan to reflect the use on nonslip strips placed by the resident's bed for the fall of 12/25/14.

The revised policy and procedure date 9/25/14 titled Process for Care Plan Development and Communication revealed the direct care nurse would date the resident ' s care plan as the resident ' s needs change.

The facility failed to update the resident's care plan with had a history of falls.

- The Annual Minimum Data Set (MDS) dated 4/17/14 for resident #96 revealed the resident had long term memory impairment. The resident could recall current season, location of room and knew he/she was in a nursing home. He/she required total assistance while bathing.

The Activities of Daily Living (ADL's) Care Area Assessment signed on 5/1/14 revealed the resident was non verbal and required extensive to dependent assistance with ADLs.

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The Quarterly MDS dated 12/4/14 revealed the resident had long term memory impairment. The resident could recall current season, location of room and knew he/she was in a nursing home. He/she required total assistance while bathing.

The Care plan updated 1/2/15 revealed the resident preferred 3 showers a week in the evening.

Review of the bathing schedule revealed the resident was scheduled to receive his/her baths on Tuesdays and Fridays during the 6 A.M. to 2 P.M. shift.

Review of the shower sheet documentation revealed the resident received 2 showers a week during November, December and January.

Review of the Plan of Care Conference Summary dated 1/23/14 revealed the resident/spouse requested to change bathing to in the morning, two times a week.

Observation on 1/13/15 at 8:13 A.M. the resident sat in his/her wheelchair in the commons area, the resident shook his/her head yes that he/she received a shower that morning.

Interview on 1/7/15 3:42 P.M. the residents spouse voiced concerns that the resident was not receiving the amount of showers as requested.

On 1/12/15 at 11:54 A.M. direct care staff V stated he/she was the bath aid and provided baths according to the schedule located in the cabinet on each hall. He/she voiced resident #96 received his/her shower around 6:15 A.M. on Tuesdays and Fridays. When a shower was given

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F 280	Continued From page 19 a shower sheet was turned into the licensed nursing staff. On 1/13/15 at 10:55 A.M. licensed nursing staff H voiced direct care staff V followed the bathing schedule and completed the showers sheets on each resident. He/she would expect the residents' care to be reflected on his/her care plan. Licensed nursing staff may update the care plans as needed, but the MDS coordinator usually did this. On 1/13/15 at 1:34 P.M. administrative nursing staff E stated during care plan meetings bathing preferences were reviewed, he/she was unaware of why the care plan stated 3 showers a week in the evening and the resident was receiving 2 in the morning. He/she expected the care plan to reflect the 2 baths a week in the morning and licensed nursing staff and the MDS coordinator were expected to update the care plan. On 1/13/15 at 2:18 P.M. administrative nursing staff D voiced he/she expected the care plan to be updated to reflect the care the resident was receiving. The policy and procedure for Process for care plan development and communication provided by the facility revised 9/25/14 revealed direct care nurses would update the residents' care plan when changes arose. The facility failed to update this residents' care plan to reflect bathing preferences.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 100 residents. The sample included 21 residents. Based on observation, record review, and interview, the facility failed to assess the dialysis port for 1(#108) resident, failed to provide completed bladder assessments for 3 (#39, #96, and #82), failed to monitor the bowel movements of 1 (#42) resident, and failed to promptly obtain a lab specimen for 1 (#73) resident in the sample.

Findings included:

- The signed Physician's Order Sheet (POS) dated 12/4/14 for resident #108 revealed a diagnosis of chronic kidney disease stage V (an advance disease of the kidneys).

The quarterly Minimum Data Set (MDS) dated 11/6/14 revealed a Brief Interview for Mental Status (BIMS) score of 12 (moderately impaired cognition) and received dialysis (the process of diffusing blood across a semipermeable membrane to remove toxic materials, maintain fluid, electrolytes in cases of impaired kidney function) services.

The dialysis care plan reviewed 11/14/14 revealed staff would monitor the resident for

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changes in her/his cognition and monitor her/his electrolyte values and notify the physician of any change in behavior. The resident attended dialysis on Tuesday, Thursday, and Saturday and staff would monitor lab work as ordered and would communicate changes with the dialysis center. Staff would monitor the resident's dialysis site on her/his left arm for signs and symptoms of infection and would notify the physician and dialysis center. Staff would obtain the resident's weight before and after dialysis and notify the physician, dialysis center, and family of any significant weight change.

Observation on 1/13/15 at 3:05 P.M. licensed nursing staff I removed the resident's left arm from her/his long sleeved shirt, inspected the dialysis port, placed the resident's shirt back on, listened to the resident's lung sounds, and then left the resident's room.

Nursing staff I failed to assess the resident's dialysis port for thrill and bruit upon the resident's return from dialysis.

On 1/13/15 at 3:10 P.M. licensed nursing staff I stated she/he checked the dialysis port for bleeding and would not check the dialysis port for thrill and bruit.

On 1/13/15 at 3:35 P.M. administrative nursing staff D stated she/he would expect staff to check a dialysis port for bleeding and the dialysis staff to check the dialysis port for thrills/bruits.

The policy and procedure dated 1/1/01 titled Hemodialysis Guidelines revealed staff would frequently check the shunt for obstruction. Staff would use a stethoscope, or place fingertips on

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the area between the cannula insertion points to detect bruit or thrill. The presence of a bruit or a thrill indicated free flow of blood through the shunt.

The facility failed to assess a dialysis shunt post dialysis per policy for this resident with a diagnosis of ESRD and who received dialysis services.

- The quarterly Minimum Data Set (MDS) dated 11/12/14 for resident #39 revealed a Brief Interview for Mental Status score of 7 (severe cognitive impairment). The resident required limited assistance of one person for toileting, used a walker for mobility, and frequently incontinent of urine.

The Urinary Incontinence Care Area Assessment (CAA) dated 8/22/14 revealed the resident required assistance with activity of daily living (ADL's) and toileting needs. The resident had problems recognizing urinary urges due to cognitive problems. The resident was admitted to the facility for a fall with a hip fracture.

The care plan reviewed on 11/19/14 revealed staff assisted the resident to change her/his pull-ups as needed and provided pericare when the resident was incontinent of bowel and bladder. Staff would offer the resident assistance to the bathroom upon arising, before meals, after meals, at bedtime, and as needed when the resident asked to go.

The Medicare Admission Nursing Notes dated 8/12/14 revealed the resident was both continent and incontinent of urine.

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Record review on 1/12/15 at 10:07 A.M. revealed incomplete 3-day Voiding Diaries dated 8/12/14 to (-) 8/14/14 and 11/12/14 - 11/14/14.

The Bladder Incontinence Assessment dated 8/18/14 was incomplete and lacked an analysis of finding for the resident's urinary incontinence.

Record review on 1/12/15 at 10:10 A.M. lacked documentation a Bladder Incontinence Assessment was completed for the 3-Day Voiding Diary of 11/12/14 - 11/14/14.

Observation on 1/13/15 at 12:54 P.M. the resident sat in a wheelchair in the bathroom. She/he stated she/he finished using the toilet, was unable to reach the toilet handle, and required assistance flushing the toilet.

Interview on 1/12/15 at 3:45 P.M. direct care staff W stated the resident was not incontinent of urine in the evenings and called for assistance with toileting if needed. Staff initiated a 3-Day Voiding Diary upon admission and submitted the form to the nurse when completed.

Interview on 1/12/15 at 4:15 P.M. licensed nursing staff K stated the resident wore briefs and was not always incontinent of urine. The resident was able to transfer her/his self to the toilet and called for assistance if needed. Nursing staff reviewed 3-day voiding diaries when completed and used information from the 3-day voiding diary to complete a Bladder Incontinence Assessment.

Interview on 1/13/15 at 12:16 P.M. administrative nursing staff F stated the resident was occasionally incontinent of urine and toileted as

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needed. Nursing staff should review and complete the backside of the 3-Day Voiding Diary. The information on a 3-Day Voiding Diary was used to complete a Bladder Incontinence Assessment form. Nursing staff should complete all sections of the Bladder Incontinence Assessment form. Staff should have completed a Bladder Incontinence Assessment form when the 3-Day Voiding Diary of 11/12/14 - 11/14/14 was completed.

On 1/13/15 at 3:35 P.M., administrative nursing staff D stated staff should complete all sections of the 3-Day Voiding Diary and Bladder Incontinence Assessment. Staff should have completed a Bladder Incontinence Assessment form for the 3-Day Voiding Diary of 11/12/14 - 11/14/14.

The revised policy and procedure dated 6/30/06 titled Bladder Elimination Assessment revealed each resident would be assessed on admission to determine bladder continence or incontinence. If it was determined that a resident was incontinent an in-depth assessment would be completed using the Bladder Incontinence Evaluation form. The resident would be re-assessed if there was a significant change in status and annually. A 3-day bowel and bladder flow sheet would be completed on each incontinent resident. The nurse would review the data from the Bladder Incontinence Assessment and 3-Day Bowel/Bladder Flow Sheet to determine if the resident was a candidate for a re-training program.

The facility failed to fully assess this resident for urinary incontinence.

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- The Annual Minimum Data Set (MDS) dated 4/17/14 revealed resident #96 had long term memory impairment. The resident could recall current season, location of room and knew he/she was in a nursing home. He/she was incontinent of bladder and required total assistance with toileting.

The Urinary incontinence Care Area Assessment signed on 5/1/14 revealed the resident was non-verbal and required total assistance with toileting.

The Quarterly MDS dated 12/4/14 revealed the resident had long term memory impairment. The resident could recall current season, location of room and knew he/she was in a nursing home. He/she was incontinent of bladder and required total assistance with toileting.

The Care plan updated on 1/2/15 revealed the resident was incontinent of bladder and assistance of two staff members with toileting. The resident was assisted to the bathroom when he/she awoke, before and after meals, at bedtime and when the resident requested. Staff assisted the resident with peri-care after each incontinent episode.

Review of the bladder incontinence assessment dated 12/30/14 revealed after the 3 day bowel and bladder flow sheet was completed, the facility reviewed the flow sheet and determined if a bladder retraining program would be implemented.

Review of the 3 day bowel and bladder flow sheet dated 12/30/14 through 1/1/15 revealed the

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resident's bladder incontinence assessment was completed on 12/1/14, before the 3 day bowel and bladder flow sheet was completed.

Constant observation from 1/12/15 at 8:04 A.M. to 11:47 A.M. revealed:

Observation on 1/12/15 at 8:04 A.M. the resident was assisted in his/her wheelchair out of the dining room to his/her room, where the resident sat in his/her wheelchair watching television until 1/12/15 at 10:39 A.M.

Observation on 1/12/15 at 10:39 A.M. the resident's spouse pushed him/her in wheelchair to the common area for an activity where he/she remained until 1/12/15 at 11:47 A.M. when the spouse took the resident to the dining area.

Observation on 1/12/15 at 3:16 P.M. direct care staff O and direct care staff Q changed the residents dry brief while he/she was in bed. Direct care staff O and Q transferred the resident to his/her wheelchair.

Interview on 1/7/15 3:42 P.M. the residents spouse voiced concerns that the resident was not assisted to the restroom and his/her brief was changed while the resident was in bed.

On 1/12/15 at 10:45 A.M. direct care staff U voiced the resident was not assisted to the restroom and his/her brief was changed while in bed. He/she voiced the morning of 1/12/14 he/she was working on that hall and was not changed between breakfast and lunch because the resident was not incontinent.

On 1/12/15 at 2:56 P.M. direct care staff Q voiced

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the resident was not assisted to the restroom and staff changed his/her brief while in bed.

On 1/13/15 at 10:55 A.M. licensed nursing staff H revealed the facility needed to re-evaluate the resident's voiding status and bladder incontinence assessment for accurate care the resident should receive. He/she was aware that staff do not assist the resident to the restroom and voiced direct care staff provided peri-care while he/she was in bed.
On 1/13/15 at 1:34 P.M. administrative nursing staff E stated the licensed nursing staff completed the bladder incontinence assessment and he/she reviewed them when completed and acknowledged the 12/30/14 bladder incontinence assessment was inaccurate. He/she was unaware if the resident was assisted to the restroom, but expected his/her staff to follow the care plan.
On 1/13/15 at 2:18 P.M. administrative nursing staff D voiced he/she expected staff to follow the care plan and take the resident to the restroom. He/she acknowledged the bladder incontinence assessment dated 12/30/14 was not completed correctly.
The policy and procedure for Bladder Elimination Assessment provided by the facility revised on 6/30/06 revealed the facility ensured each resident who was incontinent of urine was identified, assessed and provided appropriate treatment and services through an interdisciplinary approach, to achieve or maintain as much normal urinary function as possible.

The facility failed to accurately complete a bladder incontinence assessment and assist the resident to the restroom at the set times the care plan reflected.

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- Resident # 82 had diagnosis listed on the Physicians Order Sheet (POS) dated of 1/1/15 of Fall, Alzheimer ' s (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain), Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living).

The Quarterly Minimum Data Set (MDS) dated7/28/14 listed long and short term memory problems. He/she rarely makes decisions. He/she required extensive assistance of 1staff member for transfers, toileting, dressing, and personal hygiene. He/she required limited assistance of 1 staff member for moving on/off the unit. The assessment identified the resident did not have a toileting program, and was frequently incontinent of urine with at least one episode of continent voiding.

The Significant Change MDS dated 10/21/14 listed long and short term memory problems. He/she rarely made decisions. He/she required extensive assistance of 2 staff members for bed mobility, transfers, dressing, and toileting. He/she required total assistance of 1 staff member for moving on/off the unit, eating and personal hygiene. He/she used a wheelchair with staff assistance for mobility. The assessment identified the resident did not have a toileting program, and was always incontinent of urine.

The Care Area Assessment (CAA) for urinary

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incontinence dated 10/27/14 revealed the resident required a prostatectomy (the surgical removal of the prostate gland, the whole or part of) due to prostate cancer he/she was incontinent since 2/14/13 and was at risk for complications associated with incontinence, will care plan.

The care plan dated reviewed on 11/4/14 for urinary incontinence stated the resident experienced bladder incontinence related to dementia. He/she was unable to make his/her needs known. He/she would not experience skin issues or urinary tract infections, staff were to apply moisture barrier to the skin, and complete the bowel and bladder diary for 3 days to determine a toileting schedule with the results from the 3 day diary.

Review of the 3 day bowel and bladder evaluation dated 7/17/14 did not address the number of episodes the resident was continent or incontinent of bladder. The bladder incontinence assessment dated 7/17/14 was not completed in the areas of surgery, medication regimen, associated symptoms, pattern of fluid intake, skin status, or environmental factors. The second page containing the summary was blank.

The 3 day bowel and bladder evaluation dated 8/19/14 did not address the number of episodes the resident was continent or incontinent of bladder. The facility failed to provide a bladder incontinence assessment for this evaluation.

The 3day bowel and bladder evaluation dated 10/15/14 did not address the number of episodes the resident was continent or incontinent of

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bladder. The bladder incontinence assessment dated 10/15/14 listed the contributing factors diagnosis of dementia and cerebral vascular accident, the medication regimen area was not completed, the resident was listed as alert and oriented x1, his/her vision and hearing were adequate, he/she had transfer standing ability, voiding Pattern was listed as after meals, and no apparent pattern. The resident had multiple daily episodes of little or no control with complete relief after voiding, no bladder distention and no residual urine. The resident prefers to drink juice, his/her skin was intact and staff were to assure a clear pathway to the toilet. The remainder of the assessment was blank.

On 1/12/15 at 1:00 P.M. resident sat in the common area of the unit watching television, drinking water, the resident is dressed appropriately to the season, his/her clothing was dry.

On 1/12/15 at 4:00P.M. the resident participated in the ball toss activity resident ' s clothing remained dry.

On 1/12/14 at 3:35 P.M. direct care staff XX stated the resident was toileted every 2 hours last time was 2:30 P.M. and he was wet. He/she was incontinent of bowel and bladder.

On1/13/15at 7:40 A.M. Direct care staff ZZ and YY provided morning care to the resident. Direct care staff YY stated the resident required total care, he/she was always incontinent of bowel and bladder. Staff check and change the resident if necessary every 2 hours.

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On1/13/15 at 8:15 A.M licensed staff N stated he/she could not answer the question for how the incontinence pattern was determined based on the assessments of 7/17/14, 8/19/14, and 10/15/14.

On1/13/15/ at 8:20 A.M licensed nurse HH stated the bladder evaluation forms of 7/17/14, 8/19/14, and 10/15/14 were not completed to determine the type incontinence for this resident.

Review of the facility policy for Bladder Assessment dated revised 6/30/06 revealed each resident would be assessed on admission to determine bladder continence. If it was determined that the resident was incontinent an in-depth assessment would be completed using the Bladder Incontinence Evaluation Form. He resident would be re-assessed if there was a significant status change and annually. A 3-day bowel and bladder flow sheet would be completed on each incontinent resident. Utilizing the Evaluation Form and the Flow sheet the recommendation would be made.

The facility failed to provide complete bladder assessments for this cognitively impaired dependent resident.

- Resident #42's annual Minimum Data Set (MDS) dated 10/30/14 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, did not have behaviors, required extensive staff assistance with bed mobility, transfers, dressing, toilet use, required

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supervision with locomotion on/off the unit and limited staff assistance with personal hygiene. The MDS identified the resident had an indwelling catheter and was continent of bowel.

The resident's Activity of Daily Living Care Area Assessment (CAA) dated 11/4/14 included the resident required staff assistance with activities of daily living. The resident had a diagnosis of metastatic prostate cancer (the development of cancer in the prostate), stage 3 chronic renal disease (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), and diabetes mellitus Type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). The resident required staff assistance for mobility, transfers, toileting and had a suprapubic catheter.

The resident's Pain CAA dated 11/4/14 included the resident was at risk for pain due to diagnoses of prostate cancer, arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement) and gout (inflammation of the joints).
The resident's care plan dated 11/5/14 required staff assistance with ADL's due to weakness in the progression of his/her prostate cancer. The resident's care plan included staff encouraged the resident to drink fluids to help prevent dehydration (the excessive loss of body water, with an accompanying disruption of metabolic processes) and to keep the resident's bowels regular.

On 1/8/15 at 3:22 P.M. the resident's care plan did not include interventions regarding constipation or the resident's bowel pattern.

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Review of the resident's bowel monitoring log for 10/15/14 to 1/12/15 revealed the resident had a bowel movement (BM) on 12/19/14 between 2:30 P.M. and 10:30 P.M. Further review of the documentation revealed the resident did not have another BM until 12/25/14 between 2:30 P.M. and 10:30 P.M. (duration of 5 days). The resident's clinical record lacked evidence the facility administered an as needed PRN) laxative (substances that loosen stools and increase bowel movements and used to treat and prevent constipation) during the above time frame. The resident's clinical record also lacked evidence the facility assessed or spoke to the resident regarding not having a BM for 5 days.
Review of the resident's December 2014 bowel pattern revealed the resident had a BM on the average of every 3 days.

A nurse's note dated 12/26/14 and timed 2:00 P.M. documented the resident sat on the bedside commode and complained of constipation. The nurse attempted to insert a suppository without success. The resident had firm bowel in his/her rectum with small pebble size pieces of stool coming out when the nurse removed his/her finger. The nurse asked the resident to sit on the beside commode and bare down as the stool was right there.

A nurse's note dated 12/26/14 and timed 2:30 P.M. the resident was not able to push the hard stool out and the nurse assisted with the digital removal of the dry hardened stool. The resident was able to pass the stool on his/her own after removal of the large impacted stool and the resident tolerated procedure. Staff administered pain medication prior to removal of the stool and staff continued to monitor the resident.

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F 309	Continued From page 34 On 1/13/15 at 4:35 P.M. nursing administrative staff F stated the resident received Senna (laxative and an aid to treat constipation) twice a day. He/she stated the resident's care plan addressed the resident's normal bowel pattern was every 5 to 6 days. On 1/13/15 at approximately 4:30 P.M. nursing administrative staff D stated if a resident had not had a BM in 3 days, the facility administered a laxative unless the facility had determined the resident's bowel pattern indicated the resident did not routinely have a BM for 5 to 6 days. Review of the resident's care plan faxed to the state agency on 1/14/15 revealed an hand written entry on the resident's care plan dated 1/13/15 that noted the resident's normal bowel pattern was 5 to 6 days. The facility failed to monitor this resident's bowel pattern and failed to develop a care plan that addressed the resident's constipation for this resident that required manual digital removal of hardened stool.	F 309		

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- The annual Minimum Data Set (MDS) dated 11/5/14 for resident # 73 revealed he/she had unclear speech, was sometimes able to make him/herself understood, and was independent in his/her decision making. The resident required extensive assistance from 2 or more staff members for bed mobility and transfers. He/she was dependent on staff for locomotion on/off the unit, bathing, and eating. He/she received 51% or more of his/her calories and fluids from a feeding tube.

The 11/13/14 care area assessment regarding tube feedings revealed the resident received supplemental nutrition through a feeding tube and was reliant on staff assistance due to a diagnosis of Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder).

The care plan with a revision date of 12/31/14 revealed staff monitored the resident's feeding tube site for signs of irritation such as redness, drainage, leakage, and pain and as of 11/25/14 had the diagnosis of cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) around the tube. As of 11/13/14 staff provided labs as ordered by the resident's physician.

The Situation Background Assessment Notification (SBAR) found in the nurse's notes (NN) dated 11/25/14 revealed inflammation around the resident's feeding tube started on 11/23/14 had worsened, now with a white center.

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Staff received physician orders to transfer to the hospital emergency room for evaluation.

The NN dated 11/25/14 at 1:30 P.M. revealed the resident returned to the facility with new orders for an antibiotic.

The NN dated 11/26/14 at 2:25 P.M. revealed the facility received a new physician's order for a culture for the resident's feeding tube site.

The NN dated 11/27/14 at 9:00 P.M. revealed the feeding tube insertion site continued to be inflamed, red, tender, and had a small amount of drainage around the site.

The NN dated 11/28/14 at 8:00 P.M. revealed the feeding tube site was slightly inflamed and had small amounts of drainage.

The NN dated 11/29/14 at 5:30 A.M. revealed staff was unable to flush the tube due to inflammation and oozing of a yellowish liquid around the site.

The late entry, untimed NN dated 11/30/14 revealed the resident was highly agitated most of the day and swinging his/her arms which caused dislodgement of the feeding tube.

The NN dated 11/30/14 at 6:10 P.M. the feeding tube site continued to be inflamed and painful to touch.

The NN dated 12/1/14 at 1:30 P.M. revealed staff was waiting on the laboratory to bring specimen tubes for the culture of the feeding tube site.

The NN dated 12/2/14 at 3:00 A.M. revealed the

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feeding tube site had yellow, green drainage and staff collected the specimen for the ordered wound culture.

Observation on 1/12/15 at 8:09 A.M. revealed the resident sat in a recliner in his/her room watching a movie.

Interview on 1/12/15 at 3:51 P.M. with licensed nursing staff K revealed staff was to collect lab orders as soon as possible. Staff K would expect them to obtained the same day as the order unless the order specified a certain date or time.

Interview on 1/13/15 at 10:59 A.M. with administrative nursing staff F revealed the facility did not have culture swabs available when this resident's order was made. Staff F would expect lab orders to be collected with in 24 hours of being ordered. He/she reported staff should have been documenting as soon as it was noticed that the swabs were not available to collect the culture. Staff F stated it was the responsibility of the nurse who noticed the facility was running low on lab supplies to call and request more to be delivered.

Interview on 1/13/15 at 2:16 P.M. with administrative nursing staff D revealed the facility did not have a policy regarding a timeframe to collect lab orders made by the physician but he/she expected them to be completed within 24 hours of the order. Staff D expected documentation showing there was an issues regarding obtaining an ordered lab. He/she acknowledged 7 days was not timely for lab specimen collection of a physician's order.

The facility failed to obtain an ordered culture

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F 309	Continued From page 38 timely for this resident with continued inflammation and tenderness at his/her feeding tube site.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 100 residents. The sample included 21 residents. Based upon observation, record review and interview the facility failed to provide necessary treatment and services to prevent the development of pressure ulcers and promote healing for 2 of 2 residents sampled for pressure ulcers (#41, #52). Findings included: - Review of the resident #41's January 2015 Physician Order Sheet (POS) identified the resident was admitted to the facility on 12/8/14 with diagnoses of right femoral and pubic rami fractures (broken pelvic and thigh bone). The resident's admission Minimum Data Set (MDS) dated 12/15/14 identified the resident scored 14 (cognition intact) on the Brief Interview	F 314		

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for Mental Status, had no behaviors, required extensive staff assistance with bed mobility, transfers, dressing, toilet use, bathing and locomotion on/off the unit. The MDS identified the activity of walking in the room/corridor did not occur, required staff supervision with eating and limited staff assistance with personal hygiene. The MDS identified the resident was occasionally incontinent of urine, always continent of bowel and was not on a toileting program. The MDS recorded the resident weighed 96 pounds, was at risk for the development of pressure ulcers, did not have any unhealed pressure ulcers, had a pressure reducing device on his/her bed and in his/her chair and was not on a turning/repositioning program.

The resident's Activity of Daily Living Care Area Assessment (CAA) dated 12/17/14 CAA included the resident required staff assistance for mobility, transfers, locomotion, toileting and bathing. The resident's pain limited his/her ability to function fully and the resident was non-weight bearing on his/her right leg.

The resident's Nutritional Status CAA dated 12/17/14 included the resident was at risk for an alteration in skin due to a recent fall which resulted in fractures of the pelvic/thigh and pain.

The resident's Pressure Ulcer CAA dated 12/17/14 included the resident was at risk for skin breakdown secondary to requiring extensive staff assistance for mobility (leg/pelvic fracture). The resident risks included incontinence, mobility needs, potential for friction and shearing and the resident was underweight.

The resident's Braden Scale (scale used to

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predict the development pressure ulcers) dated 12/8/14 identified the resident scored 14. According to the legend a score of 13 to 14 represented the resident was at moderate risk for the development of pressure ulcers.

The resident's care plan developed on 12/17/14 and revised on 12/22/14 addressed the resident had an alteration in his/her activity of daily living (ADL) abilities related to a fracture of the femur and pelvic fracture and required staff assistance with ADLs. The resident enjoyed sitting in his/her recliner. The resident received a regular diet, staff encouraged the resident to drink fluids and eat snacks. The Registered Dietician (RD) evaluated the resident annually and as needed, staff administered supplements and weighed the resident as physician ordered. The resident was at risk for skin problems related to incontinence, staff applied cream to the resident's buttock as physician ordered, the resident utilized a foot cradle on his/her bed to keep the covers off of his/her feet, had a low air loss mattress (pressure relieving device), staff monitored the resident's skin during bathing, the licensed nurse performed weekly skin assessments and reported open areas to the resident's physician and staff performed the Braden Scale on a quarterly basis. The care plan addressed the resident was at risk for bowel and bladder incontinence. Staff performed laboratory testing as indicated. An entry dated 12/18/14 included staff placed a pressure relieving device in the resident's recliner and offered the resident Carnation Instant Breakfast. An entry dated 12/22/14 included the resident had (2) Stage 2 pressure ulcers on his/her sacrum (large triangular bone between the two hip bones) . Staff cleaned the pressure ulcers with soap and water and patted dry,

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applied Duoderm (dressing used to promote the healing of wounds) and changed the dressing every 72 hours and as needed until healed.

The resident's care plan did not include a turning/repositioning schedule/program for the resident. The care plan did not include how staff protected skin to skin contact of the resident's bony prominence's.

A hospital History and Physical dictated 12/3/14 included the resident's total protein was 5.5 grams per deciliter (g/dL), normal reference range (6.0 to 8.0 g/dL).

A RD note dated 12/16/14 included the resident was recently admitted to the facility, was underweight and was at risk for an alteration in his/her skin. The resident's calorie needs were met and the resident consumed approximately 55 to 60 percent (%) of meals. There was no albumin level (blood test used to measure the amount of protein in the blood, used in part to determine a person ' s nutritional status) for the RD to review and staff offered the resident snacks. The RD recommended the resident receive 120 cubic centimeters (cc) of Carnation Instant Breakfast(beverage fortified with protein and nutrients) three times (TID) at meals, a Multivitamin with minerals and Calcium with Vitamin D once a day.

A RD note dated 12/23/14 included the resident's current weekly weight identified the resident weighed 95 pounds which was down 4 pounds and the resident had open areas. There were no laboratory results (albumin level) to review and staff had implemented the 12/16/14 recommendations. The vitamins and Carnation

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Instant Breakfast supported the resident's intake and skin repair.

A RD note dated 1/7/15 included the resident continued with the (2) Stage 2 wounds on his/her coccyx, the resident consumed approximately 50% of meals. The resident stated he/she would like chocolate milkshakes. The RD recommended 120 cc's of Carnation Instant Breakfast or a similar supplement four times per day (or similar supplement) and to offer super cereal at the breakfast meal to increase the resident's calories/protein and to promote healing.

The resident's Weekly Wound Tracking Form included the following:

12/16/14: The resident had shearing (an applied force or pressure exerted against the surface and layers of the skin as tissues slide in opposite but parallel planes) on his/her coccyx that was facility acquired that measured 0.5 centimeters (cm) by 0.5 cm. Staff applied Calmoseptine (moisture barrier) every shift and as needed and left the area open to air.
12/24/14: (2) Stage 2 facility acquired pressure ulcers on his/her coccyx. Pressure ulcer number (#) 1 measured 1.5 cm by 0.2 cm, pressure ulcer #2 measured 0.75 cm by 0.75 cm by 0.1 cm and staff treated the area with Duoderm.

12/31/14: Pressure ulcer #1 was a Stage 2 and measured 1.0 cm by 1.0 cm by 0.2 cm. Pressure ulcer #2 was healed. Staff continued to treat the area with Duoderm.

1/7/15: Pressure ulcer #1 was a Stage 2 and measured 1.0 cm by 0.5 cm, pressure ulcer #2

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remained healed and staff treated the area with Duoderm.

Review of the resident's December 2014 and January 2015 Medication Administration Record (MAR) on 1/13/15 at approximately 9:45 A.M. revealed the resident had received the Multivitamin with mineral, Calcium with vitamin since 12/19/14. Further review revealed the resident had received the Carnation Instant Breakfast since 12/18/14. Review of the MAR also revealed from 12/19/14 to 1/5/15 the facility did not record the percentage of the Carnation Instant Breakfast the resident received. The MAR documented the facility offered the Carnation Instant Breakfast in the AM (no time specified), at 12:00 P.M. and during the PM (no time specified). Review of the MAR did not support the facility offered the resident the Carnation Instant Breakfast four times a day as recommended by the RD on 1/7/15.

On 1/12/15 at 8:20 A.M. observation revealed the resident's bed had a low air loss mattress.

On 1/12/15 at 8:23 A.M. the resident sat in his/her wheelchair in the dining room and ate the breakfast meal which consisted of bacon, waffle, milk, juice and coffee. The observation did not reveal the resident had super cereal. Observation revealed the resident had eaten a bite or 2 of the waffle and 75% of the bacon.

On 1/12/15 at 8:48 A.M. direct care staff SS wheeled the resident from the dining room. Observation revealed the resident had consumed all of the bacon, 50% of the waffle and milk and 75% of the juice and coffee.

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On 1/12/15 at 9:00 A.M. direct care staff TT and SS transferred the resident from his/her wheelchair to his/her recliner via a sliding board. The resident yelled out twice during the transfer. The resident stated he/she had a sore on his/her bottom, his/her bottom was hurting which was why he/she yelled out during the transfer. The resident stated he/she developed the sore a couple of weeks ago. The resident stated the sore was due to him/her sitting for long periods of time. The resident stated staff did not routinely position him/her. Observation revealed the resident's wheelchair and recliner had pressure relieving devices.

On 1/12/15 at 12:20 P.M. the resident sat in his/her wheelchair in the dining room. Observation revealed the resident ate a fruit salad.

On 1/12/15 at 12:40 P.M. the resident sat in his/her wheelchair in the dining room eating the lunch meal which consisted of 6 fried shrimps and pudding. Observation revealed the resident consumed 1 1/2 pieces of the shrimp, 75% of the fruit salad and 50% of the pudding. At that time staff wheeled the resident from the dining room.

On 1/12/15 at 2:25 P.M. the resident laid in bed on his/her left side. Observation did not reveal a foot cradle on the resident's bed. Further observations revealed the resident's feet were not offloaded nor were there devices between the resident's knees.

On 1/12/15 at 2:30 P.M. the resident laid in bed on his/her left side. Observation did not reveal a foot cradle on the resident's bed. Further observations revealed the resident's feet were not

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off-loaded nor were there devices between the resident's knees.

On 1/12/15 at 2:42 P.M. the resident laid in bed on his/her left side. Observation did not reveal a foot cradle on the resident's bed. Further observations revealed the resident's feet were not offloaded nor were there devices between the resident's knees.

On 1/12/15 at 3:00 P.M. administrative nursing staff F entered the resident's room. Administrative nursing staff F stated the resident complained that his/her bottom was hurting and he/she was going to assess the resident's bottom. Observation revealed the Duoderm in a rolled position on the resident's coccyx and per administrative nursing staff F the resident was starting to have a bowel movement. Administrative nursing staff F removed the Duoderm and cleansed the area. After the Duoderm was removed and the area was cleansed the resident stated the pain was better. Administrative nursing staff F stated the resident had a pinpoint scabbed area on his/her coccyx. Observation confirmed administrative nursing staff F statement. Further observation revealed scar tissue adjacent to the pinpoint scabbed area. Nursing administrative staff F stated the resident had also had another pressure ulcer on his/her coccyx which was healed and the scar tissue was where the previously pressure ulcer was.

On 1/13/15 at 9:15 the resident sat in his/her wheelchair at a dining room table. Observation revealed the resident had consumed 50% of the milk.

On 1/13/15 at 9:26 A.M., 9:42 A.M. and 9:55 A.M.

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the resident sat in the recliner in his/her room.

On 1/13/15 at 9:25 A.M. review of the resident's dietary card did not identify the resident received the Carnation Instant Breakfast with meals or super cereal at breakfast. Dietary staff II stated nursing and not dietary staff offered/served the Carnation Instant Breakfast to the resident.

On 1/13/15 at 8:45 A.M. administrative nursing staff F stated the facility recorded the percentage of the Carnation Instant Breakfast the resident consumed.

During interview with direct care staff UU on 1/13/15 at approximately 9:26 A.M. stated the resident received the Carnation Instant Breakfast at 10:00 A.M. and dietary staff included it on the 10:00 A.M. snack cart. Direct care staff UU stated the resident received Resource at 12:00 P.M. instead of the Carnation Instant Breakfast.

Review of the snack roster on the 10:00 A.M. snack cart on 1/13/15 at 10:30 A.M. did not include the resident's name.

On 1/13/15 at 11:45 A.M. dietary staff DD stated the dietary department did not send the resident's Carnation Instant Breakfast (CIB) on the snack cart. He/she supplied the surveyor with a snack roster and confirmed the resident's name was not on the roster. Dietary staff DD stated if dietary supplied the CIB on the snack cart it would be included on the snack roster. Dietary staff DD stated he/she was not aware of the RD's 1/7/15 recommendations until 1/13/15. Dietary consultation HH stated the normal process was that the RD faxed the recommendations to the resident's physician on the date of the

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recommendations but the RD that made the recommendations on 1/7/15 was not aware of the process and did not fax the recommendations to the resident's physician on 1/7/15.

On 1/13/15 at approximately 1:30 P.M. dietary consultant HH stated the Carnation Instant Breakfast should be offered/provided at meal times and he/she was not aware the resident did not receive it at meals. He/she stated if staff provided Resource versus the Carnation Instant Breakfast, it should be included separately on the MAR. He/she confirmed the RD on 1/13/14 recommended the resident received 120 cc's of the CIB 4 times a day and for the facility to offer the resident super cereal at breakfast. Dietary consultant HH stated the facility did not need a physician's order for the super cereal.

On 1/13/15 at 2:16 P.M. administrative nursing staff F stated the dietary department delivered the resident's AM CIB on the snack cart each day around 10:00 A.M. to 10:30 A.M. each day. He/she stated dietary staff included the resident's 12:00 P.M. CIB with the resident's meal. Administrative nursing staff F stated he/she was not sure if the resident was on a turning/repositioning program.

On 1/13/15 at 2:47 P.M. direct care staff VV stated the resident at times required staff assistance. He/she stated the resident was not on a turning/repositioning program. Dietary care staff VV stated the P.M. snack cart did not include CIB for the resident.

On 1/13/15 at 3:15 P.M. licensed nurse N stated if dietary did not provide the CIB on the night snack cart, CIB was in the north pantry and staff

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prepared the CIB from the north pantry and gave it to the resident. Licensed nurse N showed the surveyor the CIB in the north kitchen pantry. Observation revealed (2) boxes of CIB both labeled with an open date of 11/19/14. Review of the box revealed prior to opening each box contained 10 packets of CIB. Further review revealed (1) box had 5 packs of CIB and the other box had 9 packs of CIB.

The facility failed to implement a turning/repositioning schedule for this resident the facility assessed at risk for the development of pressure ulcers upon admission and developed a facility acquired pressure ulcer. The facility also failed to timely follow-up on the Registered Dietician recommendations and failed to ensure the resident received the Carnation Instant Breakfast for this resident with a low protein level and developed a facility acquired pressure ulcer. The facility failed to develop a care plan that included a turning/repositioning program for this resident that required extensive staff assistance with transfers and bed mobility.

- Resident #52's Significant Change Minimum Data Set (MDS) dated 12/17/14 identified the resident scored 8 (moderate impaired cognition) on the Brief Interview for Mental Status, displayed verbal behaviors 1 to 3 days of the 7 day assessment period and did not reject care. The MDS identified the resident required extensive staff assistance with bed mobility, transfers, toilet use and locomotion on/off the unit, limited staff assistance with personal hygiene and the activity of walking in the room/corridor did not occur. The MDS identified the resident was always

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incontinent of urine,and had a condition or chronic disease that may result in life expectancy of less than 6 months. The MDS identified the resident was at risk for the development of pressure ulcers, had (1) Stage 2 pressure ulcer present upon admission/readmission, had a pressure relieving device on his/her bed and in his/her chair and was not on a repositioning/turning program.

The resident's Activity of Daily Living CAA dated 12/18/14 included the resident was weak from a recent hospitalization for pneumonia (inflammation of the lungs)/respiratory failure (respiratory system failed in one or both of its gas exchange functions) and received hospice services. The resident required extensive and at times was totally dependent upon staff for mobility, transfers, bathing, locomotion, dressing, toileting and eating. The resident does not walk and relied on staff or family to propel his/her wheelchair.

The resident's Incontinence CAA dated 12/18/14 included the resident had a history of incontinence especially at night. The resident had a diagnosis of dementia which may impair his/her ability to make a decision that he/she needed to toilet or ask for assistance.

The resident's Nutritional Status CAA dated 12/18/14 included resident's serum albumin was low at 2.7 grams per deciliter and the resident had a Stage 2 pressure ulcer on his/her coccyx upon readmission.

The resident's Pressure Ulcer CAA dated 12/18/14 included the resident required significant staff assistance to reposition himself/herself, was

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incontinent of urine and bowel and was overweight. The resident's Braden Scale score was 14, the resident had a low albumin, indicators the resident was at high risk for skin breakdown. The resident was a diabetic, had a history of leg wounds and had a diagnosis of Peripheral Artery Disease (abnormal condition affecting the blood vessels) and severe arthritis (-inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement). The resident's dementia (progressive mental disorder characterized by failing memory and confusion) limited his/her ability to make safe decisions. The resident had behaviors of refusing cares and yelling at staff. The resident was admitted from a hospital with a wound on his/her coccyx area and received hospice services for Chronic Obstruction Pulmonary Disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The resident's care plan dated 12/23/14 included the resident had a diagnosis of dementia and the resident's behavior made him/her resistive to care. The resident was admitted to hospice service on 12/11/14 for COPD. The resident required staff assistance with bed mobility, transfers, getting in/out of the bed and with toileting due to weakness and arthritis. The resident utilized transfer bars to help him/her with bed mobility and transfers. The resident received a regular diet and was overweight. The Registered Dietician (RD) visited the resident annually and as needed and staff weighed the resident as indicated. The resident was at risk for skin problems due to incontinence, requiring staff assistance with mobility. The resident had a pressure ulcer on his/her bottom, utilized a heel

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up device in bed which elevated the resident's legs and decreased edema. The resident utilized a low air loss mattress, staff monitored the healing of the resident's pressure ulcer, staff monitored the resident's skin during bathing and the licensed nurse performed weekly skin assessments, quarterly Braden scale (scale used to predict the development of pressure ulcers) assessments and treated the pressure ulcer as physician ordered.

The resident's care plan did not include a turning/repositioning program nor did it include the resident refused the Pro-Stat (liquid protein supplement). The resident's care plan did not include the education staff provided to the resident/family regarding the consequences of refusal of care and treatment to promote the healing of the pressure ulcer.

A physician order dated 9/15/14 included the resident required a bed with a special foot rise.

A hospital's Discharge Papers dated 12/11/14 documented the resident had a Stage 3 pressure ulcer on his/her sacrum. Staff cleansed the area with saline, applied skin preparation around the area, Duoderm extra thin (dressing used to promote the healing of wounds) with strips of hypafix tape on all edges, and to change the dressing every 2 days and more often as needed. Staff offloaded the resident with regular repositioning off of his/her back, the resident would benefit from a pressure redistribution mattress overlay and the resident utilized bilateral heel and elbow protectors.

A hospital's Discharge Summary with an admission date of 12/4/14 and discharge date of

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12/11/14 included the resident's admission laboratory results recorded the resident's serum albumin level decreased at 2.7 grams per deciliter (g/dL), normal reference range 3.4 - 5.4 grams per deciliter (g/dL). Final diagnoses included the resident had a pressure ulcer on the sacrum/ coccyx that was unstageable, present on admission and was now a Stage 3 pressure ulcer.

The resident's Admission/Readmission Skin Check dated 12/11/14 (date of readmission from the hospital) included the resident had an open area that measured 1.5 centimeters (cm) by 1.5 cm and redness around the wound measured 8.0 cm by 5 cm. The area circled on the form indicated the open area was on the resident's coccyx/buttock area.

The resident's Initial Wound Evaluation (not dated) included the resident had a hospital acquired Stage 2 coccyx pressure ulcer that measured 1.5 cm by 1.5 cm. The resident was incontinent of bowel and bladder and was non-complainant at times with check and change.

The resident's shower sheet/body check dated 1/5/15 included the resident had no open ulcers.

A nurse's note (NN) dated 12/18/14 and timed 2:45 P.M. included staff spoke with a hospice nurse, requested a physician's order for a renal multivitamin (MVI) and Pro Stat (nutritional supplement). The hospice nurse did not give the order for the MVI and Pro Stat and stated hospice would not cover the items. The note included the facility would speak with the resident's Durable Power of Attorney (DPOA) to see if he/she wanted to pay for the Pro Stat.

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Review of the resident's clinical record on 1/13/14 lacked evidence to support the facility spoke with the resident's DPOA regarding the Pro Stat.

A RD note dated 12/16/14 included the resident had a Stage 3 pressure ulcer, was admitted to hospice on 12/11/14 and received a renal MVI.

A RD note dated 1/7/15 included the resident's weight was stable for the past 3 months, the resident received hospice services for COPD and the resident required 2179 calories and 73 grams of protein each day to promote healing and Hospice disapproved the MVI and Pro Stat for healing.

The resident's daily wound assessment for the week of 12/20/14 included documentation dated 12/17/14 included there was change in the resident's wound, maceration (softening and breaking down of skin resulting from prolonged exposure to moisture) surrounded the wound, the wound bed was not visible and contained yellow slough. Staff would speak with hospice regarding a new treatment.

The resident's daily wound assessment dated 12/24/14 documented the wound bed of the pressure ulcer was gray.

The daily wound assessments lacked measurements of the wound.

Review of the resident's weekly wound log revealed the following:
12/16/14: The pressure ulcer was a Stage 3 the previous week was a Stage 3, was currently a Stage 2 that measured 1.5 cm by 1.5 cm and the current treatment was Optifoam which staff

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BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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changed every other day.
12/24/14: The Stage 2 coccyx pressure ulcer measured 1.0 cm by 1.5 cm and the current treatment was Duoderm
12/31/14: Stage 2 coccyx pressure ulcer measured 1.0 cm by 1.0 cm
01/7/15: Stage 2 coccyx pressure ulcer that measured 1.0 cm by 1.0 cm and the current treatment was Duoderm.

A physician's order dated 12/23/14 included for staff to apply Santyl (a debriding agent) to the wound bed of the resident's pressure ulcer, cover with Optifoam and secure with Duoderm. Change every 3 days and as needed.

Review of the resident's Treatment Administration Record (TAR) for December 2014 and January 2015 included staff cleansed the pressure ulcer with wound cleanser, patted the area dry, applied Calzime cream, covered the pressure ulcer with Optifoam after applying skin preparation. Staff changed the dressing every 3 days and as needed and checked to ensure the dressing was in place each day. The TAR also included notation that read For Your Information (FYI) staff turned the resident every 2 hours and to keep the resident off of his/her coccyx.

The TAR did not include documentation to support staff turned the resident every 2 hours and kept the resident off of his/her coccyx.

The resident's clinical record lacked evidence to support the facility explored/implemented other food items to increase the amount of protein in the resident's diet to promote healing.

On 1/12/15 at 8:20 A.M. the resident sat on the

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side of his/her bed. The resident had just eaten the breakfast meal. During interview, the resident stated he/she received bacon, scrambled eggs with cheese on top and toast. The resident raised the lid off of the breakfast tray and observation revealed the resident consumed all of the bacon, 50% of the eggs and 75% of the toast. The resident stated the empty cups contained coffee and cranberry juice.

On 1/12/15 at 9:00 A.M. the resident laid in bed on his/her back. Observation revealed the residents had a low air loss mattress on his/her bed and a pressure relieving device in his/her wheelchair. Observation revealed no heel up device in place, the resident's feet were not off-loaded and nothing between the resident's legs to prevent skin to skin contact.

On 1/12/15 at 9:40 A.M. direct care staff SS and TT were in the resident's room. Observation revealed the resident the resident had a pressure ulcer in the crease of his/her buttock that measured approximately 1.0 cm by 0.5 cm and the middle of the wound bed with yellow slough. Further observation revealed no dressing covering the pressure ulcer. At 9:48 A.M. direct care staff SS and TT transferred the resident from the bed to his/her wheelchair via the mechanical lift.

On 1/12/15 at 12:00 P.M. the resident sat in his/her wheelchair at a dining room table and consumed the lunch meal which consisted of a bowl of chili, whole kernel corn and a corn bread muffin. At 12:15 P.M. the resident had finished eating the meal and observation revealed the resident consumed 100% of the chili and muffin and 50% of the corn.

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On 1/12/15 at 3:12 P.M. direct care staff WW, XX and SS transferred the resident from the wheelchair to his/her bed via a mechanical lift. Observation revealed the resident was incontinent of bowel. Staff provided incontinent care and applied moisture barrier to the resident's buttock. Observation revealed no dressing on the resident's pressure ulcer. Direct care staff WW stated staff applied moisture barrier and the resident did not utilize a dressing on his/her pressure ulcer.

On 1/13/15 at 7:30 A.M. the resident laid in bed on his/her back. Observation revealed the heel up device against a wall, the resident's feet were not off loaded, and no device between the resident's legs to prevent skin to skin contact. The resident stated staff placed the heel up device when he/she went to bed, after about 30 minutes he/she kicked the device out of the bed and staff placed the device against the wall sometime during the night.

On 1/13/15 at 8:15 A.M. and 8:20 A.M. the resident sat in the dining room in his/her wheelchair.

On 1/13/15 at 8:40 A.M., 8:50 A.M., 9:00 A.M., and 9:10 A.M., the resident sat in his/her wheelchair in his/her room.

At 9:25 A.M. the resident propelled himself/herself to his/her doorway. Staff propelled the resident to the activity room to attend the resident council meeting.

The resident attended the resident council meeting from 9:25 A.M. until 10:05 A.M.

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F 314	Continued From page 57 On 1/13/15 at 10:11 A.M.,10:26 A.M.,10:40 A.M.,10:50 A.M.,11:00 A.M. and 11:15 A.M. the resident sat in his/her wheelchair in his/her room. On 1/13/15 at 10:15 A.M. direct care staff UU stated staff did not reposition the resident during the resident council meeting. The above represented the resident sat in the wheelchair from 8:15 A.M. until 11:15 A.M. (duration of 3 hours) without a change in position. On 1/13/15 at approximately 1:30 P.M. dietary consultant staff HH stated hospice refused to pay for the MVI and the Pro Stat, therefore the resident did not receive it to promote healing. Dietary consultant staff HH stated he/she recommended MVI and Pro Stat to promote healing even if a resident received hospice services. On 1/13/15 at 2:16 P.M. administrative nursing staff F stated hospice refused the MVI and the Pro Stat. He/she stated the resident was readmitted from the hospital with a pressure ulcer. Administrative nursing staff F stated the resident's hospital paperwork documented the pressure ulcer was a Stage 3; however facility staff staged it a Stage 2 at the time of admission. He/she stated the pressure ulcer was currently a Stage 2 pressure ulcer. Administrative nursing staff F stated the resident should have a dressing on the pressure ulcer and direct care staff should inform the nurse when the dressing was not in place. On 1/13/15 at 2:35 P.M. direct care staff VV	F 314		

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F 314	Continued From page 58 stated staff turned/repositioned the resident every 2 hours. Direct care staff VV stated the resident had a pressure ulcer on his/her coccyx, staff applied moisture barrier on the area and he/she had not observed a dressing on the area. On 1/13/15 at approximately 4:20 P.M. administrative nursing staff D stated he/she was not aware of the situation regarding the Pro Stat. He/she stated if the family refused to pay for the Pro Stat the facility would incur the cost. Administrative nursing staff D stated he/she was aware there was no evidence to support the facility treated the pressure ulcer with Santyl as physician ordered and stated he/she did not know why staff did not provide the treatment as physician ordered. The facility failed to develop a care plan that included an individualized turning/repositioning program, failed to follow up on the dieticians recommendations and failed to follow the physician's order to promote healing of the pressure ulcer.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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The facility reported a census of 100 residents. The sample included 21 residents. Based on observation, record review and interview the facility failed to provide fall interventions for one (#9) of 4 residents sampled for accidents. The facility failed to store hazardous chemicals out of reach of cognitively impaired residents on 1 of 3 units, 2 of 4 days while onsite.

Findings included:

- The Significant Change Minimum Data Set (MDS) dated 4/15/14 revealed resident #9 had moderate impaired cognition. The resident required supervision of one staff member for transfers and limited assistance of one staff member for toilet use. He/she was at risk for falls and had 2 non-injury falls since the prior assessment.

The Fall Care Area Assessment (CAA) signed on 4/29/14 revealed the resident was at risk for falls and required supervision to limited assistance from staff with transfers.

The Quarterly MDS dated 12/11/14 revealed the resident had severe cognitive impairment. He/she required extensive assistance of one staff member for toileting and extensive assistance of two staff members for transfers. The resident had experienced no falls since prior assessment.

The care plan updated on 12/23/14 revealed the resident was at risk for falls, had a history of falls and a bed/chair alarm was used for safety.

Review of the Physician's Order Sheet for 1/1/15-1/31/15 revealed staff checked for functioning of the bed and chair alarms every shift.

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Observation on 1/12/15 at 3:42 P.M. resident was in his/her wheelchair with no chair alarm in place.

On 1/12/15 at 4:23 P.M. resident was in his/her wheelchair with no chair alarm in place.

On 1/13/15 at 11:28 A.M. resident was in his/her wheelchair with no chair alarm in place.

Interview on 1/13/15 at 8:35 A.M. direct care staff R stated the resident had a bed and chair alarm for safety. The facility was responsible for putting the chair alarm in the resident's wheelchair while the resident was in his/her wheelchair.

On 1/13/15 at 10:05 A.M. direct care staff T voiced the kardex (a sheet that was used by staff that identified the needs of the residents) only said bed and chair alarms. Direct care staff T was unsure if the resident was to have the chair alarm in the wheelchair.

On 1/13/15 at 10:09 A.M. licensed nursing staff I voiced the direct care staff would sometimes transfer the chair alarm to the wheelchair, but was mainly used while the resident was in his/her room.

On 1/13/15 at 1:34 P.M. administrative nursing staff E stated he/she expected staff to place the chair alarm in any chair the resident was sitting in, including his/her wheelchair.

On 1/13/15 at 2:18 P.M. administrative nursing staff D voiced the resident would have the chair alarm in place no matter what surface the resident sat on.

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F 323	Continued From page 61 The policy and procedure provided by the facility for standards of patient care dated 11/15/2010 revealed the patient recieved care by personal care staff to reduce the risk of physical injury. The facility failed to follow fall interventions as planned for this cognitively impaired resident with a history of falls.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: The facility had a census of 100 residents. Based upon observation and interview the facility	F 353		

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failed to ensure sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

Findings included:

- During stage 1 of the survey several residents and family members stated the facility did not have sufficient nursing staff and expressed concerns that staff did not respond to call lights in a timely manner.

On 1/8/15 observation revealed a resident on the north unit activated his/her call light at 2:53 P.M. Observation revealed the resident's call light remained unanswered until 3:04 P.M. (a duration of 10 minutes).

On 1/12/15 observation revealed a resident on the north unit activated his/her call light at 10:08 A.M. Further observation revealed staff did not answer the resident's call light until 10:19 AM. (a duration of 11 minutes).

On 1/12/15 observation revealed a resident on the north unit activated his/her call light at 12:06 P.M. Further observation revealed staff answered the resident's call light at 12:19 P.M. (a duration of 13 minutes. Further observation revealed the resident reactivated the call light at 12:37 P.M. Observation at 12:43 P.M. (duration of 7 minutes) revealed staff responded/deactivated the resident's call light. Observation revealed the resident reactivated his/her call light at 12:47 P.M. and observation revealed staff had not responded to the resident's

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call light at 12:54 (duration of 7 minutes).

The surveyor and a staff member entered the resident's room at 12:54 P.M. The staff asked the resident if he/she was done eating the lunch meal, the resident responded yes and the staff removed the lunch tray from the resident's room. The staff did not ask the resident why his/her call light was activated. The resident informed the surveyor he/she activated his/her call light at 12:06 P.M., staff responded and he/she requested Morphine for pain and he/she had not received the pain pill as of 12:54 P.M. The resident stated he/she should receive Reglan prior to eating his/her meal and staff had not administered the Reglan at that time.

On 1/12/15 at 12:30 P.M. direct care staff UU assisted staff to transfer another resident from the wheelchair to his/her recliner.

During interview with direct care staff UU at 1:07 P.M. the staff confirmed the resident had not received the Reglan or the Morphine. Review of the resident's Medication Administration Record revealed the resident received Reglan 10 milligrams (mg) four times a day before meals and had an order to receive 30 mg of Morphine. A hand written entry noted staff administered the Reglan 30 minutes before meals. At 1:12 P.M. direct care staff UU administered the 30 mg of Morphine to the resident and asked the resident if he/she still wanted the Reglan since he/she had eaten the lunch meal. The resident responded yes and direct care staff administered the Reglan at 1:13 P.M.

On 1/12/15 a resident on the north unit activated his/her bathroom call light at 12:41 P.M.

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Observation revealed staff answered the resident's call light at 12:48 P.M. (duration of 6 minutes).

On 1/12/15 at 3:29 P.M. a resident on the north unit activated his/her bathroom call light. Observation revealed staff answered the resident's call light at 3:39 P.M. (a duration of 10 minutes).

On 1/13/15 at 7:31 A.M. a resident on the north unit activated his/her call light at 7:31 A.M. Observation revealed staff did not respond to the resident's call light until 7:45 A.M. (duration of 14 minutes).

On 1/13/15 at 7:55 A.M. a resident on the north unit activated his/her call light. Observation revealed staff had not responded to the resident's call light at 8:10 A.M. (a duration of 10 minutes).

On 1/13/15 at 1:00 P.M. a direct care staff member stated having 5 or 6 Certified Nurse Aides on the day shift was sufficient. He/she stated if staff call in, the facility pulled staff from other units. The direct care staff stated if there was no staff to pull from another unit the facility had the bath aide to work the floor. Direct care staff stated quite often there are not 5 direct care staff working the floor and at times only 3 which was not sufficient to care for the residents.

On 1/13/15 at 1:14 P.M. a direct staff member stated if 6 Certified Nurse Aides were scheduled and all showed up for duty one of the staff was sent home. He/she stated 5 direct care staff providing direct care was sufficient but at times there were less than 5 which was not sufficient.

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F 353	Continued From page 65 On 1/13/15 at 2:19 P.M. an administrative nursing staff stated the facility utilized matrix to determine staffing patterns and it was dependent upon the census of the facility. He/she stated the on-call staff either manually telephoned staff or sent out a text alert to staff if a staff member called in. He/she stated if a bath aide was pulled from the floor then the Certified Nurse Aides responsible for care that day provided the baths. He/she stated restorative staff provided restorative nursing service staff but also provided direct care. The administrative nursing staff stated at times resident's/family members expressed concerns regarding sufficient staffing. On 1/13/15 at 2:50 P.M. a direct care staff stated at times nursing staff was not sufficient. He/she stated he/she at times was pulled to other units and could not perform all of his/her assigned tasks. The staff stated residents and family members had expressed concerns regarding staff response time to call lights. The facility failed to provide sufficient nursing staff to ensure resident's call lights were answered in a timely manner and to ensure residents received medications as physician ordered.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 100 residents. Based on 3 of 4 days of observation in 2 of 3 dining rooms and 1 of 2 main kitchens, the facility failed to serve and prepare food in a sanitary manner.

Findings included:

- During an observation on 1/7/15 at 11:25 A.M. in the South building dining room, the dietary staff entered and exited the kitchen during service witout hair being fully covered with appropriate hair covering.

An observation on 1/7/15 at 9:55 A.M. in the North main kitchen revealed a staff member pulled out a tray of unwrapped raw chicken from the walk in refrigerator and pushed the tray back in with his/her foot.

An observation on 1/7/15 at 9:28 A.M. in the South main kitchen revealed 1 box of beef patties in a refrigerator that was open to air.

An observation on 1/7/15 at 9:55 A.M. in the North main kitchen the refrigerator revealed 1 opened plastic bag of shrimp, 1 opened bag that contained 2 pieces of liver, 1 opened bag that contained 1 country fried steak.

An observation on 1/8/15 at 7:52 A.M. in the South building dining room revealed a staff member wore a hair net with hair outside of the net all around his/her head.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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An observation on 1/12/15 at 9:12 A.M. in the South building kitchenette one staff members pony tail remained fully outside of his/her hairnet during the dining service.

An observation on 1/12/15 at 11:50 A.M. in the North main kitchen, staff wore gloves and cut one piece of chicken, placed it on noodles, picked up parmesan cheese by his/her gloved hand, put it onto the noodles and parmesan that remained in his/her hand was put back into the container with parmesan cheese.

An interview on 1/7/15 at 9:55 A.M. with dietary staff GG stated food items should not be open to air in the refrigerators.

An interview on 1/13/15 at 12:46 P.M. with dietary staff II stated staff wore hairnets so the hair did not get into the food. When he/she saw staff with hair sticking out of their hairnet, he/she would let them know.

An interview on 1/13/14 at 8:49 A.M. with direct care staff U stated the certified nurse aides (CNA's) did enter and exit the kitchen during dining service and the front office and kitchen staff were responsible for telling other staff members if hair was not covered by the hairnet.

An interview on 1/13/15 at 11:10 A.M. with administrative nursing staff F stated staff that entered the dinette area were to wear hairnets.

An interview on 1/13/15 at 9:23 A.M. with dietary staff DD stated all staff monitor the hairnets. All hair should have been covered by staff when entering and exiting the kitchens. Staff were not

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F 371	Continued From page 68 supposed to push items with their feet, they were to use their hands to store items in the refrigerator. He/she expected gloves to be changed and hands to be washed when gloves were removed. An interview on 1/13/15 at 9:48 A.M. with dietary staff GG stated staff who supervised were to monitor hairnet use and he/she did expect all hair to be covered. He/she expected food trays to be pushed back with hands and never feet. Anytime staff touched their body, go from dirty to clean staff were expected to wash their hands. Anytime staff went to a different food type they were expected to change their gloves. The undated Food and Dining Sanitization/Food Safety Checklist policy provided by the facility included all hair should be covered and food should be handled proplerly by staff. The facility failed to serve and prepare food in a sanitary manner.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		

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appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
- On 1/7/15 at 10:00 A.M. a bottle of Lasix 80 mg, with an expiration date of 12/20/14, was noted in a medication cart on the south unit.

On 1/7/15 at 10:05 AM direct care staff MM stated all nursing staff check medication carts for expired medications.

On 1/13/15 at 1:00 P.M. licensed nursing staff I stated nursing staff checked the medication carts for expired medications. Expired medications were removed from the medication care and placed in the medication room to be destroyed.

On 1/13/15 at 3:35 P.M. administrative nursing

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staff D stated nursing staff using the medication carts should review the cart for expired medications.

The policy and procedure dated 5/28/02 titled Medication Management Guidelines revealed staff would store drugs in an orderly manner in cabinets, drawers or carts. No discontinued, outdated or deteriorated drugs would be retained for use. All drugs must be returned to the issuing pharmacy or destroyed in accordance with state regulations governing the destruction of medication.

The facility failed to remove an expired medication from a medication cart.

The facility identified a census of 100 residents. The sample included 21 residents. Based on observation, record review, and staff interview the facility failed to store medications in a safe and secure manner and dispose of one expired medication on 1 of 3 units.

Finding included:

- During an observation on 1/8/15 at 8:09 A.M. an unlocked cabinet on the South 300 hall revealed a large carrier that contained 2 Levemir Flex touch prefilled insulin syringes, 1 Pramlintide acetate pen injector, 1 Lantus solostar insulin glargine prefilled syringe, 2 Novolog flex pens prefilled syringes, 1 Humolog Kwikpen insulin lispro injection pen, 1 levemir 10 milliliter bottle, 1 tube of Lidocain and prilocain cream usp 2.5%, 1 box of no fine autocover 0.3 by 8 mm, and 1 box of 29 gage by 1.2 inch monoeject 1 milliliter insulin syringe.

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F 431	Continued From page 71 An interview on 1/8/15 at 9:11 A.M. with licensed nursing staff H stated the insulin container should have been locked inside of the medication room. An interview on 1/13/15 at 8:01 A.M. with administrative nursing staff E stated the medications were to be kept in the locked medication room. An interview on 1/13/15 at 2:45 P.M. with administrative nursing staff D stated he/she expected medications to be locked up. The facility provided a form that revealed there were 8 cognitively impaired and independently mobile residents in the South hall. The facility's medication management guideline policy, dated 5/28/02, revealed medications must be stored in an appropriately lighted, locked storage area accessible to authorized personnel only. The facility failed to store medications in a safe and secure manner.	F 431		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		

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issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 100 residents. Based on interview and record review, the medical director did not routinely participate in the quarterly Quality Assurance(QA) meetings in the last 11 months.

Findings included:

Review of the facility provided sign-in sheets for the Quarterly meeting documented the medical director attended 1 meeting in September of 2014.

On 1/13/15 at 5:00 P.M. Administrative staff A confirmed the medical director did not attend the QA meetings routinely per the sign in sheet.

The medical director failed to attend the quarterly QA meetings